Women's Satisfaction with Primary Care: A New Measurement Effort from the PHS National Centers of Excellence in Women's Health

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Women's Satisfaction with Primary Care: A New Measurement Effort from the PHS National Centers of Excellence in Women's Health

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Abstract This paper describes efforts by the National Centers of Excellence in Women's Health to develop a woman-specific primary care satisfaction instrument suitable for quality improvement and research.

Recently, there have been a number of calls for improved quality indicators in women's health care and for incorporating women's perspectives in quality measures.[1–3] Since women are a majority of health care consumers, make about 60% of outpatient visits,[4,5] and are key decision makers for their own and their family members' health care,[6] their assessments of the quality of care are likely to be critical to health plan purchasing and utilization decisions. Furthermore, because women are more experienced and knowledgeable health care consumers than men,[7] a better

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understanding of what women value in health care could be useful in improving primary care services for all consumers. Simultaneously, there has been increased investment in women's health research and in developing new health care delivery models for women's primary care.[8] An example of this movement is the U.S. Public Health Service Office on Women's Health (OWH) recent designation of 18 National Centers of Excellence (CoE) in Women's Health. The CoEs' mandate is to develop and evaluate innovative approaches to providing integrated women's health care. While integrated models incorporating all primary care services for women have become popular, these models have not been evaluated for patient satisfaction against the more traditional model where women received routine reproductive care from an obstetrician/gynecologist and non-reproductive health care from an internist or family physician.

VIEWS ON GENDER IN THE SATISFACTION LITERATURE

With the exception of some instruments designed for gender-specific services (e.g., prenatal care), most outpatient satisfaction instruments now in use have not been developed with gender issues in mind and may not be sensitive to women's utilization patterns or specific concerns. Indeed, it has been suggested that patient satisfaction measures typically are developed to minimize differences in experiences or expectations by sociodemographic variables, such as gender, in order to produce clearer health policy implications.[9] The problem with this approach, however, is that generic instruments may not estimate women's satisfaction levels accurately and may be of limited usefulness for quality improvement.

SELF–FULFILLING PROPHECY

Ignoring potential gender-specific issues in instrument development can lead to a blurring of the unique health care experiences faced by women. The existing literature contains conflicting reports regarding the relationship between gender and satisfaction with health care. Some authors report a preponderance of evidence that women are more satisfied than men with medical care received,[10] and some report that women are more critical of medical care than men.[11] On the assumption that gender is associated with reporting of satisfaction, some investigators treat gender as a "patient mix" variable and adjust for it in analyses of between-plan differences.[12] Analyses of gender differences in satisfaction levels using standard instruments have reported mixed results. In a meta-analysis of 110 studies of satisfaction with inpatient and outpatient care, Hall and Dornan (1990)[13] conclude that there is no average difference in satisfaction with medical care (both inpatient and outpatient) between men and women. The "no difference" result could reflect the insensitivity of existing instruments to women's health care patterns and concerns.

Other data suggest that there may be important differences in how women and men evaluate health care. A recent study of gender differences in the predictors of patients' overall satisfaction with their primary care physicians in one managed care plan found that the direction of effects for most independent variables were similar for women and men but that effect sizes differed by gender.[14] Some structural aspects of health plans, such as the perceived ease of changing physicians or scheduling appointments, have stronger effects on women's overall satisfaction than on men's. Women also appear to be more likely to act on their dissatisfaction with care: the 1998 Commonwealth Fund

Survey of Women's Health found that 18% of women ages 18 and over, compared with 9% of men, reported that they had changed physicians due to dissatisfaction in the past 5 years. (The remaining persons had either never changed physicians or changed physicians for other reasons.) Among those who had changed physicians due to dissatisfaction, communication problems were the most frequently cited reason (e.g., perceiving that the physician did not listen to them or was condescending). Aspects of the health care process that are particularly important to women (e.g. the quantity, content, or style of communication) may not be measured adequately in standard patient satisfaction instruments.

TAILORING SATISFACTION SURVEYS FOR WOMEN

Given the increased interest in monitoring quality of care for women and the inconclusive findings of previous gender comparisons, better methods for assessing satisfaction which capture women's unique needs, experiences, and expectations are needed. Previous work has drawn attention to specific issues in comprehensiveness and coordination in women's primary care, particularly with respect to the fragmentation of reproductive and non–reproductive components of care.[15,16] Studies of women's health care utilization patterns show that women make more visits than men per year, use a wider array of primary care providers (including physician generalists and specialists, advanced practice nurses), and often use more than one regular source of care.[15,17] In the 1998 Commonwealth Fund Survey of Women's Health, 37% of women ages 18 and older used two types of physicians for their regular care: a generalist and an obstetrician-gynecologist. Some women also may seek specific services (e.g., family planning) outside their health plans, for reasons of continuity, confidentiality, or availability of methods. In addition, while current definitions and measures of primary care contextualize it within a sustained physician-patient relationship,[18,19] women may have multiple simultaneous relationships with providers.

These complex patterns of care mean that satisfaction measures that focus on care received at a specific visit or episode may be more useful for evaluating women's health care than those that require respondents to rate their experience over time and across providers. Visit-specific information may also be more interpretable in research and quality improvement efforts, since the information provides a direct link with an episode of care and with a provider.

Women's expectations of health care, their differing roles in using the health care system for themselves and family members, and their unique health needs also have implications for the design of satisfaction instruments. Expectations may be shaped by past experiences with the health care system (either through their own care or experiences getting care for a family member) or by an idealized conception of what care should be. The use of expectancy models in assessing satisfaction for women may be particularly helpful, since gender has an important impact on expectations of care, orientations to care, and interactions between patients and providers. For example, women's expectations of care may be shaped by their unique roles in health care seeking. Women in focus groups frequently discuss health care expectations not just in terms of their own experiences, but also their experiences obtaining care for others, including children, spouses, or parents. Women's frequent encounters with health care may raise (or lower) their expectations for some aspects of care, such as the timeliness of appointments, the clarity of communication with providers, or the availability of timely follow-up care. In addition, more preventive care is recommended for women than men in early adulthood and in connection with reproduction (e.g., routine gynecological exams, prenatal

care). Based on their experiences, women may develop greater expectations for preventive services. Little conceptual validation has been performed with patient satisfaction instruments currently in use, however, and none has considered gender issues in expectations for care or in the gap between expectations and perceived care.

Finally, some attention should be addressed to the unique concerns of women. Women-specific aspects of care (e.g., such as access to female providers or comfort during gynecological/pelvic examinations) are not included in instruments intended for use in both women and men, and thus require special instrumentation. The construction, analysis, and interpretation of satisfaction instruments should consider women's unique needs and roles. For example, access issues might be evaluated differently by women and men because, for example, women's primary health care is organized differently or women confront specific barriers to care (e.g., less discretionary time, lack of enabling services such as child care).

CONSORTIUM FOCUS GROUP PROJECT

To address this need for a measure of women's satisfaction with primary care, six of the OWH–designated CoEs initiated a joint measure development project. In 1998, CoEs' at the University of Michigan, Wake Forest University, Magee–Women's Hospital, University of California at San Francisco, University of Pennsylvania, and Boston University collaborated on a multi-site focus group project to begin the development of a primary care satisfaction survey for women, with supplemental funding from the OWH. The objective was to conduct the formative work necessary to develop a set of patient satisfaction items based on women's needs and perspectives. As described by Krueger (1994),[20] the advantages of using focus groups in this manner include the fact that a) the social nature of the interaction often stimulates participants to reveal information that might not be accessible as part of other data gathering formats, b) the format allows the moderator to probe unanticipated issues that arise during the discussion, and c) the procedure is relatively low cost and produces almost immediate results.

Each of the participating centers conducted at least three focus groups of women recruited from the community, with a total of 23 groups and 193 participants. (Table 1) Community residents, rather than CoE patients, were recruited in order to ensure a variety of health care experiences and to include women who do not have access to health care. The type of recruitment varied by site, but included the use of advertisements in community newspapers, postings in clinics and primary care practices; and flyers in community centers, businesses, and churches that served the target populations for the survey. Some sites also used marketing firms to recruit subjects. Subjects were paid a nominal amount for their time, and food was served at each session. The groups were stratified by age (ages 18–34, ages 35–54, and ages 55 and over) and race/ethnicity (Latina, African American, Asian, European-American). Focus groups with lesbian participants also were conducted at two of the sites. Another site included focus groups for older women (age 75 and over) and for women with chronic medical and mental health conditions. (Table 2) About 25% of participants were publicly insured or uninsured. The women used a variety of health care sources, including managed care plans, community-based health centers, private providers, and alternative providers.

The groups were conducted by women facilitators using a focused discussion guide. Women were asked to discuss: the meaning of "women's health" and what they value in their health care; accessing health care; checking in at the appointment; provider-patient interactions during the visit;

Table 1. NUMBER OF PARTICIPANTS IN FOCUS GROUPS BASED ON AGE AND RACE/ETHNICITY

	Age Groups			
Race/Ethnicity	*18–34 years*	*35–54 years*	*55 years and over*	*Total*
African-American	14	18	15	47
European-American	18	17	17	52
Asian-American	6	7	7	20
Latina		10	8	18

other sources of health care used; and checking out and follow-up care. The groups were audio-taped, and summary reports of the groups were prepared. These summary reports were reviewed for common themes as well as themes unique to the populations studied. These themes served as the framework for the development of the Primary Care Satisfaction Survey for Women (PCSSW).

FOCUS GROUP RESULTS

The focus group discussions revealed that women generally were well informed; they were aware of recent public attention to women's health research (e.g., on heart disease, breast cancer, menopause) and of policy issues that had been in the news (e.g., health plan coverage of Viagra but not contraceptives). In discussing women's health, participants in all age groups tended to perceive health holistically and to assume the unity of physical and mental/emotional health. When asked to define "women's health," women emphasized both the reproductive and non-reproductive aspects of health and health at all stages of life. Most women recognized the importance of their own efforts in producing their health (e.g., through healthy lifestyle and obtaining good health information).

With regard to their health care, the focus groups participants tended to discuss what they valued in their health care from the perspective of their experiences in the health care system, rather than in terms of an idealized health care delivery system. For example, when asked about possible alternatives for health care (e.g., such as one-stop shopping primary care centers in which women could receive basic reproductive health services as well as other components of primary care) most women were enthusiastic about the concept, but would not have raised it on their own because it was not part of their experiences.

Age appeared to be an important correlate of health care perceptions. Younger women (ages 18 to 34) often reported extreme role overload (due to

Table 2. NUMBER OF PARTICIPANTS IN FOCUS GROUPS FOR OTHER TARGET POPULATIONS

	Age Groups			
Target Group	*18–34 years*	*35–54 years*	*55 years and over*	*Total*
Lesbian	10	17	4	31
Chronic Medical Problems	1	3	5	8
Chronic Mental Health Problems	0	7	1	8
Age 75 and older			9	9

parenting as well as working or schooling) and therefore wanted health care providers who could see them promptly when they needed care, did not keep them waiting, provided services efficiently, and were willing to provide information or prescriptions by telephone. Older women (ages 55 and over) frequently had done considerable shopping around to find providers with whom they were comfortable, and they thought that women had to select physicians carefully. Midlife women (ages 35 to 54) were the most vocal about the need for providers who are sensitive to women's specific health care needs and for services that are not merely replications of male-modeled care. Midlife women also were most likely to identify organizational or system issues related to health care quality, rather than focus solely on provider issues.

Several issues specific to racial/ethnic groups and to lesbian women were identified in the focus groups. For example, African American women were more likely than other women to identify trust in their providers as a key issue in their health care. Asian women highlighted the importance of quality of care defined by expertise and cost. Minority women of lower socioeconomic status and Medicaid enrollees were more likely than other women to identify basic access to services as a key issue, and they were less likely to be concerned about "second level" issues such as seeing female providers. Among lesbians, important concerns identified were providers' comfort levels with their sexual orientation and the appropriate inclusion of partners in the visit process.

Gender-specific issues that arose in the focus groups included: the desire to be fully clothed when talking to the physician before the examination; the preference among some women for female providers, especially for gynecological exams or when sensitive or sexual issues are involved; the desire for non-judgmental provision of reproductive services at all stages of life (addressing sexual violence, treatment for sexual dysfunction, and menopause management); the need for more physicians who are informed about women's health research and women's health resources; the need for greater flexibility in scheduling appointments around menstrual periods (e.g., to facilitate pelvic exams and quality Pap smears); the desire for adult-only, women-centered settings; and the need for on-site childcare.

Overall, there were marked similarities across groups in preferences for good communication with providers (defined in terms of both quantity and quality), comprehensiveness of care, and privacy and comfort. Aspects of care for which concurrence across groups was evident included: strong preference for physicians with good communication skills, including the ability to "invite" women to report sensitive information (e.g., sexual problems) and to respect the women's opinions; needs for more health information communicated during the visit and by telephone or internet; desire for prompt and full reports of the results of tests and procedures; preference for more services (especially preventive services) provided at one visit, rather than in multiple visits; frustration with providers who are not familiar with patients' medical records or who ask the same questions repeatedly; preference for providers who are open to alternative therapies (e.g., herbal medicine, stress management); need for assistance with referrals and follow-up services; and desire for settings that protect one's privacy in the reception and waiting areas, examining rooms, and during checkout.

A PROTOTYPE INSTRUMENT

Based on the results of these focus groups, patient satisfaction survey items were drafted and subjected to cognitive interviewing in six focus groups across CoEs (total N = 54). The aim was to construct an instrument containing items with content relevant to most women and that could be completed in under 5

minutes. The women in all groups were asked to discuss the draft items for clarity of wording, readability, and relevance (face validity and content validity) of the content. Some redundant items were identified (e.g., women thought that it was not necessary to ask about waiting time for the appointment, waiting time in the waiting area, and waiting time in the examining room) and subsequently eliminated.

A 31-item Primary Care Satisfaction Survey for Women (PCSSW) was drafted based on the results of the focus group study.[a] The items include ratings of overall quality of care, behavioral intent, and items tapping the following dimensions:

- accessing care (4 items)
- privacy and comfort (6 items)
- communication with providers (7 items)
- comprehensiveness of care (7 items)
- follow-up care (3 items)
- overall satisfaction with visit (4 items)

These dimensions reflect aspects of care that were important to women in the focus groups. Items in these domains were worded to more precisely convey the emphasis or centrality of the topic to quality care as reported by women in the focus groups. In addition, there is at least one gender-specific item within each domain. For example, the office staff's flexibility in scheduling a primary care appointment around a woman's menstrual cycle is an aspect of "accessing care" that is not relevant to men and could have direct impact on what services a woman receives during a primary care visit and on her need for a return visit (e.g., Pap smears cannot be performed when a woman is menstruating). Similarly, comfort level during the pelvic examination is a gender-specific aspect of "privacy and comfort." Finally, based on our knowledge of how primary care is organized for women, the items refer to the health care professionals that women see during visits and do not assume that there is one provider who provides all care or is perceived as the regular provider by the patient.

The instrument was designed to be administered on-site, immediately following women's primary care visits. Most of the items in the instrument use a 5–point (Excellent, Very Good, Good, Fair, Poor) response set, with an option for "does not apply." This scale was preferred by the focus group participants over a numerical (0-to-10) response set. While preliminary pilot data (N = 33) from three sites show adequate variability in responses to most items and promising reliability (Cronbach's alphas in the range of .66 to .95 across the dimensions), the instrument has not been modified for appropriate reading level or subjected to large-scale field testing to establish its psychometric properties.

NEXT STEPS IN INSTRUMENT DEVELOPMENT

A consortium of CoEs (University of Michigan, Wake Forest and Magee-Women's Hospital) has developed plans for refining and testing the PCSSW. Cognitive testing is being conducted to ensure that the wording of items is interpreted similarly by respondents and researchers. A large-scale field test is also planned to assess the reliability and validity of the instrument and to demonstrate the performance of the instrument relative to standard patient satisfaction tools. In addition, the consortium plans to assess the comparability of patient satisfaction in subgroups of women defined by age and race/ethnicity and analyzing the patient, visit, and health care variables associated

[a]More information on the instrument is available from the corresponding author. Because the instrument is still being tested, we have not included it here.

with satisfaction with primary care visits in a geographically and sociodemographically diverse sample of women.

CONCLUSIONS

This project illustrates the capacity of the CoEs to contribute to improved methods for assessing women's health care. The collaborative work of the CoEs identified the need for an instrument specifically measuring women's unique satisfaction concerns in primary care. In addition, the CoEs provided an excellent laboratory for developing this instrument because of their expertise in women's health care, their leadership in developing integrated services delivery for women, their involvement in a variety of primary care settings, and their access to geographically and sociodemographically diverse populations of female patients. Collaboration begun through the CoE project has led to additional research endeavors and promises to contribute to both our methodological and substantive knowledge about women's attitudes towards their health care.

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REFERENCES

1. Gonen JS. Quality in women's health: Taking the measure of managed care. Insights. Washington, D.C.: Jacobs Institute of Women's Health; 1998.
2. Society for the Advancement of Women's Health Research. Toward a Women's Health Outcomes Research Agenda. Washington, D.C.: SAWHR; 1998.
3. van Wijk CMT, Gijsbers KP, Kolk AM. Gender perspectives and quality of care: Towards appropriate and adequate health care for women. Social Science and Medicine 1996;43:707–720.
4. Lipkind KL. National hospital ambulatory medical care survey: 1993 Outpatient department summary. Advance Data from Vital and Health Statistics, No. 276. Hyattsville, MD: National Center for Health Statistics; 1996.
5. Schappert SM. National Ambulatory Medical Care Survey: 1994 Summary. Advance Data from Vital and Health Statistics, No. 273. Hyattsville, MD: National Center for Health Statistics; 1996.
6. Braus P. Marketing health care to women: Meeting new demands for products and services. Ithaca, NY: American Demographics Books; 1997.
7. Isaacs SL. Men's and women's information needs when selecting a health plan: Results of a national survey. Journal of the American Medical Women's Association 1997;52:57–59.
8. Weisman CS, Curbow B, Khoury AJ. The National Survey of Women's Health Centers: Current models of women-centered care. Women's Health Issues 1995;5: 103–117.
9. Fox JG, Storms DM. A different approach to sociodemographic predictors of satisfaction with health care. Social Science and Medicine 1981;15A:557–564.
10. Weiss GL. Patient satisfaction with primary medical care. Medical Care 1988;26: 383–392.
11. Kaplan SH, Sullivan LM, Spetter D. Gender and patterns of physician-patient

communication. In: Falik MM, Collins KS, eds. Women's health: The Commonwealth Fund Survey. Baltimore, MD: Johns Hopkins University Press; 1996.
12. Rubin HR, Gandek B, Rogers WH, Kosinski M, McHorney CA, Ware JE, Jr. Patients' ratings of outpatient visits in different practice settings: Results from the Medical Outcomes Study. Journal of the American Medical Association 1993;270:835–840.
13. Hall JA, Dornan MC. Patient sociodemographic characteristics as predictors of satisfaction with medical care: A meta-analyses. Soc. Sci. Med. 1990;30:811–818.
14. Kolodinsky J. Gender differences in satisfaction with primary care physicians in a managed care health plan. Women and Health 1997;26:67–86.
15. Weisman CS, Poole V. The health care delivery system and women's health: Review of the field. Working Paper 1998.
16. Clancy CM, Massion CT. American women's health care: A patchwork quilt with gaps. Journal of the American Medical Association 1992;268:1918–1920.
17. Bartman BA, Weiss KB. Women's primary care in the United States: A study of practice variation among physician specialties. Journal of Women's Health 1993;2: 261–268.
18. Donaldson MS, Yordy KD, Lohr KN. Primary care: America's health in a new era. Washington, DC: National Academy Press; 1996.
19. Safran DG, Kosinski M, Tarlov AR. The Primary Care Assessment Survey: Tests of data quality and measurement performance. Medical Care 1998;36:728–739.
20. Kruger RA. Focus groups: A practical guide for applied research. 2nd ed. Thousand Oaks, CA: Sage; 1994.